STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155154	B. WING		02/23/2012
		_	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹	2140 W	/ 86TH ST	
SPRING	MILL MEADOWS			IAPOLIS, IN 46260	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
K0000					
	A Life Safety Co	ode Recertification and	K0000		
	State Licensure	Survey was conducted by		Please accept this 2567 Plan of	
	the Indiana State	e Department of Health in		Correction for the Life Safety Survey	′
		42 CFR 483.70(a).		ending February 23, 2012 as the	
		( <del></del> )-		Provider's Letter of Credible	
	Survey Date: 02	0/23/12		Allegation. This Provider respectfull	y
	Survey Date. 02	L/ LJ/ 1 L		requests consideration for paper compliance in lieu of a revisit survey	,
	E. Hie N. J.	000074		for this Plan of Correction with a	
	Facility Number			completion date of March 19, 2012.	
	Provider Numbe				
	AIM Number: 1	100290050			
	Surveyor: Mark	Caraher, Life Safety			
	Code Specialist				
	1				
	At this Life Safe	ety Code survey, Spring			
	Mill Meadows w				
	_	Requirements for			
	_	Medicare/Medicaid, 42			
	-	3.70(a), Life Safety from			
		0 edition of the National			
		Association (NFPA) 101,			
	Life Safety Code	e (LSC), Chapter 19,			
	Existing Health	Care Occupancies and			
	410 IAC 16.2.	•			
	This two story fe	acility with a basement			
		to be of Type II (000)			
		• • • • •			
		fully sprinklered. The			
	-	e alarm system with			
		in the corridors and in all			
	areas open to the	e corridor. Smoke			
	detectors were n	ot provided in any			
		<u>-</u>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID:

TITLE

(X6) DATE

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155154	B. WING		02/23/2012
NAME OF P	PROVIDER OR SUPPLIER	- }		ADDRESS, CITY, STATE, ZIP CODE	_
		-		/ 86TH ST	
SPRING	MILL MEADOWS		INDIAN	IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		The facility has a			
		and had a census of 110 at			
	the time of this s	urvey.			
		Robert Booher, Life Safety dical Surveyor on 02/29/12.			
	Code Specialist-Me	uicai Suiveyoi on 02/29/12.			
	The facility was	found not in compliance			
	-	entioned regulatory			
		evidenced by the			
	following:	evidenced by the			
	Tollowing.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet Page 2 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 155154  NAME OF PROVIDER OR SUPPLIER  SPRING MILL MEADOWS		(X2) MU A. BUII B. WIN	DING  STREET A  2140 W	ONSTRUCTION  01  ADDRESS, CITY, STATE, ZIP CODE  86TH ST	(X3) DATE S COMPLI <b>02/23</b> /3	ETED	
					APOLIS, IN 46260	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0038 SS=E	Exit access is an readily accessible with section 7.1.  Based on observer facility failed to electromagnetic while the fire aland 19.2.1 requires ecorridor, exit distances to be in access to	ations and interview, the ensure 3 of 9 exit door locks remained unlocked rm was activated. LSC very aisle, passageway, charge, exit location, and ecordance with Chapter 1) requires doors with rrangements such as locks to unlock upon pproved fire alarm in accordance with LSC requires a fire alarm alled, tested and cordance with NFPA 72, all emergency exits fire alarm signal by stem serving the es. This deficient my residents, staff and to exit the facility from	K00	38	F K0038 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7 19.2.1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All residents have the potential to affected. A licensed contractor will be hired to rewire the magnetic lock system to be activated by a mechanism that cannot be silenced and thus during alarming, the door will continue to provide egress ever when the sound circuitry is disengaged. The magnetic lowill reactivate when the alarm system is returned to normal status and the issue is comple resolved. How will you identified to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. A licensed contractor will be hire rewire the magnetic lock system to be activated by a mechanism that cannot be silenced and the during alarming, the door will continue to provide egress ever when the sound circuitry is	.1 bed be r t en ock tely fy e d to m m us	03/19/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet Page 3 of 14

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION IDENTIFICATION NUMBER:  155154	A. BUILDING  B. WING	<u>01</u>	COMPLETED 02/23/2012
PROVIDER OR SUPPLIER MILL MEADOWS	21	REET ADDRESS, CITY, STATE, ZIP CODE 40 W 86TH ST DIANAPOLIS, IN 46260	
		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	cy. ure n
		monitored to ensure the deficient practice will not red i.e., what quality assurance program will be put into place? Maintenance Director designee will report any deficiencies found on monthly audit to monthly QAA committ for review and ensure correctivaction takes place immediately	ee ve

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 4 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	A. BUILDING 01 COMPLETED			ED.
		155154	B. WIN			02/23/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			2140 W	/ 86TH ST		
SPRING	MILL MEADOWS				IAPOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		re CC	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K0048	NFPA 101	ODE STANDARD					
SS=E		n plan for the protection of all					
		their evacuation in the event					
	of an emergency						
	Based on record	review and interview, the	K00	48	F K0048 There is a written	03	3/19/2012
	facility failed to	include the use of kitchen			plan for the protection of all		
	fire extinguishers	s in 1 of 1 written fire			patients and for their		
	safety plans for t	he facility. LSC 19.7.2.2			evacuation in the event of an emergency. 19.7.1.1 What		
	requires written l	health care occupancy			corrective action(s) will be		
	•	shall provide for the			accomplished for those		
	following:	r			residents found to have beer	1	
	(1) Use of alarms				affected by the deficient		
	` '	of alarm to the fire			practice? All residents have	the	
	department	of diariff to the fire			potential to be affected. The	au	
	*	alarms			Disaster Plan Manual onsite w be updated to include proper	"	
	(3) Response to a				procedures for extinguishing a	ny	
	(4) Isolation of fi				stove fires. The procedures in		
	(5) Evacuation o				the manual will state: Instructi	ons	
	` ′	f smoke compartment			for K-Class extinguishers: In		
		f floors and building for			case of an appliance fire, actu the appliance hood fire	ate	
	evacuation				suppression system prior to us	sina	
	(8) Extinguishme				the K-Class extinguisher or an		
	•	actice affects any			other extinguisher. How will y	-	
	residents, staff an	nd visitors in the vicinity			identify other residents havir	-	
	of the kitchen.				the potential to be affected b	-	
					the same deficient practice a		
	Findings include	<u>.</u>			what corrective action will be taken? All residents have the		
	-				potential to be affected. The	"	
	Based on a revie	w of the facility's written			Disaster Plan Manual onsite w	ill	
		tled "Fire Prevention"			be updated to include proper		
	during record rev				procedures for extinguishing a		
	_	rector from 9:20 a.m. to			stove fires. The procedures in the manual will state: Instructi		
		/23/12, the fire safety			for K-Class extinguishers: In	0110	
		ress the use of ABC type			case of an appliance fire, actu	ate	
	_				the appliance hood fire		
	ine exunguisners	s and the K class fire					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 5 of 14

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155154	A. BUILDING  B. WING	COMPLETED 02/23/2012
	PROVIDER OR SUPPLIER  MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260	•
SPRING  (X4) ID  PREFIX  TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing	INDIANAPOLIS, IN 46260  ID PREFIX TAG  PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  suppression system prior to the K-Class extinguisher or a other extinguisher. Additional all manuals in the building will located and updated with this change. What measures will put into place or what system changes will you make to ensure that the deficient practice does not recur?	using ny ny Illy, Il be s Il be mic
	system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.  3.1-19(b)	will be in-serviced on location Disaster Plan Manuals and a the procedure involving an appliance fire as it pertains to utilizing suppression hood fir How will the corrective action(s) be monitored to ensure the deficient practic will not recur, i.e., what quates assurance program will be into place? Executive Direct and Maintenance Director or designee will review the Disate Plan Manual annually and chit for appropriate updates. The Executive Director will then soff on the manual.	e lity but stor ster eck ne

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 6 of 14

STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155154	B. WIN			02/23/	2012
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2140 W	/ 86TH ST		
	MILL MEADOWS				APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
K0062 SS=C	Required automate continuously main condition and are periodically. 19 NFPA 25, 9.7.5  Based on record facility failed to enhydrants were controlled to perating and tested period Edition, the Stand Testing, and Main continuously main continuously main facility failed to be a second facility failed facility	ODE STANDARD atic sprinkler systems are intained in reliable operating inspected and tested 9.7.6, 4.6.12, NFPA 13, review and interview, the ensure 2 of 2 private fire intinuously maintained in g condition and inspected lically. NFPA 25, 1998 dard for the Inspection, intenance of Water-Based ystems at Section 4-2.2.4	K00	062	F K0062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient		03/19/2012
	inspected annual	•			practice? All residents have a potential to be affected. A	the	
		y corrective action shall			licensed contractor will be		
	_	eficient practice affects			retained to perform hydrant		
		the facility including			run-off tests on the two fire hydrants located on property.		
	staff, visitors and				How will you identify other		
	starr, vibrors are	. residents.			residents having the potentia	ıl	
	Findings include	:			to be affected by the same deficient practice and what corrective action will be		
	Based on review	of SafeCare "Fire			taken? All residents have the	:	
	Hydrant Testing"	' documentation dated			potential to be affected. A		
	10/12/10 with the	e Maintenance Director			licensed contractor will be		
	during record rev	view from 9:20 a.m. to			retained to perform hydrant		
	_	/23/12, an inspection of			run-off tests on the two fire hydrants located on property.		
		fire hydrants was not			What measures will be put in	to	
	_	the last twelve months.			place or what systemic		
	•	ew at the time of record			changes will you make to		
		tenance Director stated			ensure that the deficient		
	no other fire hydr				practice does not recur? Contract will be initiated and		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet Page 7 of 14

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155154	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 02/23/2012
	PROVIDER OR SUPPLIER MILL MEADOWS	2140 W	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	documentation was available for review and acknowledged it has been more than twelve months since the last annual inspection of the facility's two fire hydrants.  3.1-19(b)		signed to have this service do automatically every year by a licensed contractor. How withe corrective action(s) be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place? Maintenance Directo designee will review internal L Safety binder which holds all annual and quarterly safety inspections to ensure complia annually.	II cur, r or ife

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 8 of 14

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	01	COMPLE	ETED
		155154	B. WIN			02/23/2	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				/ 86TH ST		
SPRING	MILL MEADOWS				IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0144 SS=F	Generators are in exercised under month in accorda 3.4.4.1.	ODE STANDARD  Inspected weekly and load for 30 minutes per lance with NFPA 99.  Ord review and interview, load to ensure monthly load	K01	44	F K0144 Generators are inspected weekly and		03/19/2012
	_	nergency generator was			exercised under load for 30 minutes per month in		
		of 12 months using one			accordance with NFPA 99.		
		wing methods: under			3.4.4.1 What corrective		
		rature conditions, at not			action(s) will be accomplishe for those residents found to	ed	
		the Emergency Power			have been affected by the		
		meplate rating, or loading			deficient practice? All		
		e minimum exhaust gas			residents have the potential to	be	
	temperatures as r	recommended by the			affected.		
	manufacturer. C	hapter 3-4.4.1.1 of NFPA			1.The number being used to		
	99 requires mont	hly testing of generators			figure 30% of stand-by rating during load test of emergency		
	serving the emer	gency electrical system to			generator will be replaced in the	ne l	
	be in accordance	with NFPA 110.			monthly load test log to reflect		
	Chapter 6-4.2 of	NFPA 110 requires			accurate capacity. This newly		
	generator sets in	Level 1 and Level 2			corrected number is 13.5 kW.	In	
	service to be exe	rcised at least once			doing this, more load will be added during testing to suppor	- <del>+</del>	
		inimum of 30 minutes,			the 30% stand-by rating.	١	
	J .	following methods:			2.Maintenance Director or		
	_	ng temperature conditions			designee will ensure testing of		
	_	1 30 percent of the EPS			electrolyte levels in generator		
	nameplate rating				stand-by battery are completed monthly and documented	a	
	-	naintains the minimum			appropriately when test is		
	exhaust gas temp				completed.		
		the manufacturer.			How will you identify other		
		e of day for required			residents having the potentia	nl	
					to be affected by the same		
	_	ecided by the owner,			deficient practice and what corrective action will be take	<sub>n2</sub>	
	_	operations. NFPA 99,			All residents have the poten		
	3-5.4.2 requires a	a written record of			All residents have the potent	uai	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	01	COMPLETED	
		155154	B. WIN			02/23/2012	
		1	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			/ 86TH ST		
SPRING	MILL MEADOWS				APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		(2	X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPI	LETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DA	TE
	inspection, perfo	ormance, exercising			to be affected.		
	period and repair	rs shall be regularly			1.The number being used to		
	1 ^ ^	available for inspection			figure 30% of stand-by rating		
		having jurisdiction. This			during load test of emergency	_	
	-				generator will be replaced in the monthly load test log to reflect		
	deficient practice				accurate capacity. This newly	uie	
	residents, staff a	nd visitors.			corrected number is 13.5 kW.	In	
					doing this, more load will be		
	Findings include	2:			added during testing to suppor	t	
					the 30% stand-by rating.		
	Based on review	of "Emergency			2.Maintenance Director or		
		tly Exercise/Monthly			designee will ensure testing of		
		documentation with the			electrolyte levels in generator	,	
		rector during record			stand-by battery are completed monthly and documented		
		•			appropriately when test is		
		0 a.m. to 11:15 a.m. on			completed.		
		ly load testing for the			What measures will be put in	ito	
	period of 08/02/	11 through 12/06/11 was			place or what systemic		
	documented at le	ess than 30% of the			changes will you make to		
	Emergency Pow	er Supply (EPS)			ensure that the deficient		
	nameplate rating	with no exhaust gas			practice does not recur?		
		corded. Based on			Maintenance Director or desig	nee	
	_	time of observation, the			will submit the monthly log of		
					generator battery testing to Executive Director for verificat	on	
		rector acknowledged			of proper testing and		
	1	sting for the period of			documentation. How will th	e	
	08/02/11 through				corrective action(s) be		
		ess than 30% of the			monitored to ensure the		
	Emergency Pow	er Supply (EPS)			deficient practice will not rec	ur,	
	nameplate rating	g with no exhaust gas			i.e., what quality assurance		
	temperatures rec	orded.			program will be put into		
					place? Maintenance Directo	or	
	3.1-19(b)				or designee will submit the	,	
					monthly log of generator batte testing to Executive Director for		
	2 Dagad on race	ard raviany and interview			verification of proper testing ar		
		ord review and interview,			documentation. Any missed		
	1	d to ensure a complete			tests, improper documentation	, or	
	written record of	f weekly inspections of	$\perp$		deficiencies found on testing w		

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	LDING	ONSTRUCTION  01	(X3) DATE : COMPL 02/23/	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE 86TH ST APOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the starting batte generator was may weeks. Chapter requires storage connection with systems shall be not more than 7 maintained in full manufacturer's splatteries shall be immediately upo Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a written performance, exercipairs for the generator and visitors.  Findings include  Based on review Generator-Week documentation with Director during manufactor generators	ries for the emergency aintained for 15 of 52 3-4.4.1.3 of NFPA 99 batteries used in essential electrical inspected at intervals of days and shall be I compliance with becifications. Defective repaired or replaced in discovery of defects. PA 110, 6-3.6 requires batteries, including , at intervals of not more upter 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and inerator to be regularly vailable by the authority on. This deficient fect all residents, staff		be immediately corrected and brought to monthly QAA committee meeting.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 11 of 14

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER: 155154	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/23/2012
	PROVIDER OR SUPPLIER MILL MEADOWS	2140 W	ADDRESS, CITY, STATE, ZIP CODE 7 86TH ST APOLIS, IN 46260	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	recorded. Based on interview at the time of record review, the Maintenance Director acknowledged weekly emergency generator starting battery inspection records for the fourteen week period from 03/01/11 through 05/31/11 and the week of 01/31/12 was not recorded.  3.1-19(b)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 12 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE  O1 COMPL						
		155154	A. BUILDING 01		<u> </u>	02/23/2012		
		100101	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/	20.2	
NAME OF P	PROVIDER OR SUPPLIE	R			86TH ST			
SPRING MILL MEADOWS				INDIANAPOLIS, IN 46260				
(X4) ID	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
		CLSC IDENTIFYING INFORMATION)		IAG	DEFICIENCT)		DATE	
K0147 SS=E	NFPA 101 LIFE SAFETY C Electrical wiring accordance with Electrical Code. Based on observe facility failed to cords including a used as a substite NFPA 70, Article specifically permodables shall not a for fixed wiring deficient practice resident, staff or the Unit Manage floor.  Findings include Based on observe Maintenance Dir facility from 11: 02/23/12, a refri a power strip in on the second float the time of ob Maintenance Dir refrigerator was strip in the Unit second floor.	code Standard and equipment is in a NFPA 70, National 9.1.2 ration and interview, the ensure 1 of 1 extension power strips were not ute for fixed wiring. le 400-8 requires, unless mitted, flexible cords and be used as a substitute of a structure. This e could affect any evisitor in the vicinity of er's office on the second  e: ration with the rector during a tour of the 15 a.m. to 2:20 p.m. on gerator was plugged into the Unit Manager's office oor. Based on interview	K01		F K0147 Electrical wiring an equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? All residents have potential to be affected. Maintenance Director will remore refrigerator plug in the Unit Manager's office on second for from power strip and replace it with a longer cord so it can be plugged directly into wall outle Power strip will be removed frounit Manager's office. Howeyou identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to affected. Maintenance Director will remove refrigerator plug in Unit Manager's office on secon floor from power strip and replait with a longer cord so it can be plugged directly into wall outle Power strip will be removed frounit Manager's office. What measures will be put into plant.	the  ove  oor  t.  om  will  be  or  the  ace  oe  t.  om	03/19/2012	
	3.1-19(b)				or what systemic changes wi you make to ensure that the deficient practice does not	ill		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet

Page 13 of 14

PRINTED: 03/14/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155154	A. BUILDING B. WING	01 	COMPLETED 02/23/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				recur? Maintenance Director designee will perform an audit all higher amperage refrigerate in the building to ensure all are plugged directly into a wall out as opposed to a power strip. Corrections will be made as deficiencies are identified. H will the corrective action(s) be monitored to ensure the deficient practice will not reci.e., what quality assurance program will be put into place? Maintenance Director designee with track and trend usage of these high amperage appliances and inform monthly QAA committee if a trend has been identified and in need of staff education.	of ors elet  ow e  ur,  or the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: C7MS21

Facility ID: 000074

If continuation sheet Page 14 of 14